Title 23: Division of Medicaid

Part 213: Therapy Services

Chapter 1: Physical Therapy

Rule 1.11: Documentation

A. Physical therapy provider records must document and maintain records in accordance with requirements set forth in Miss. Admin. Code Part 200, Rule 1.3.

B. Required documentation by a servicing physical therapy provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment,

4. Original copies of all Outpatient Therapy Evaluation/Re-Evaluation specific to the therapy ordered,

5. The original copies of all Outpatient Therapy Plan of Care specific to the therapy requested,

6. The original copies of all tests performed or a list of all tests performed, test results, and the written evaluation reports,

7. Treatment log if treatment times are not documented in the progress notes including all requirements for timed codes as follows:

a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

c) The Division of Medicaid considers the following activities as not part of the total treatment time:

1) Pre and post-delivery of services,

2) Time the beneficiary spends not being treated, and

3) Time waiting for equipment or for treatment to begin.

d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress notes:

a) Must be documented at least weekly,

b) Must include:

1) Date/time of service,

2) Specific treatment modalities/procedures performed,

3) Beneficiary's response to treatment,

4) Functional progress,

5) Problems interfering with progress,

6) Education/teaching activities and results,

7) Conferences,

8) Progress toward discharge goals/home program activities, and

9) The signature and title of the therapist providing the service(s).

c) If treatment times are documented in the progress notes in lieu of a treatment log, all requirements for timed codes must be met as follows:

1) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

2) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

3) The Division of Medicaid considers the following activities as not part of the total treatment time:

(a) Pre and post-delivery of services. ,

(b) Time the beneficiary spends not being treated, and

(c) Time waiting for equipment or for treatment to begin.

4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

9. Discharge summary, if applicable, and

10. A copy of the completed prior approval authorization form with prior approval, if applicable.

C. Required documentation by prescribing providers must include, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders,

12. Evidence that the beneficiary was seen face-to-face and evaluated/re-evaluated every six (6) months at a minimum.

D. In addition, the prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

Source: 42 C.F.R. §§ 422.504, 485.713; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/20.

Chapter 2: Occupational Therapy

Rule 2.9: Documentation

A. Occupational therapy providers must document and maintain records in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3.

B. Required documentation by an occupational therapy servicing provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment,

4. Original copies of all Outpatient Therapy Evaluation/Re-Evaluation forms specific to the therapy ordered,

5. Original copies of all Outpatient Therapy Plan of Care forms specific to the therapy ordered,

6. Original copies of all tests performed or a list of all tests performed, test results, and the written evaluation reports,

7. Treatment log if treatment times are not documented in the progress notes including all requirements of timed codes as follows:

a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

c) The Division of Medicaid considers the following activities as not part of the total treatment time:

1) Pre and post-delivery of services,

2) Time the beneficiary spends not being treated, and

3) Time waiting for equipment or for treatment to begin.

d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress notes:

a) Must be documented at least weekly.

b) Must include:

1) Date/time of service,

2) Specific treatment modalities/procedures performed,

3) Beneficiary's response to treatment, functional progress,

4) Problems interfering with progress,

5) Education/teaching activities and results,

6) Conferences,

7) Progress toward discharge goals/home program activities, and

8) The signature and title of the therapist providing the service(s).

c.) If treatment times are documented in the progress notes in lieu of a treatment log, all requirements for timed codes must be met, Refer to timed and untimed codes in this Part.

9. Discharge Summary, if applicable, and

10. A copy of the completed prior approval form with prior approval authorization, if applicable.

C. Required documentation by a prescribing occupational therapy provider includes, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen, face-to-face, and evaluated/re-evaluated every six (6) months, at a minimum.

D. The prescribing occupational therapy provider must retain copies of the rendering provider's/ therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

Source: 42 C.F.R. §§ 422.504, 485.715; Miss. Code Ann. §§ 43-13-117, 43-13-121,.

History: Revised eff. 01/01/20.

Chapter 3: Outpatient Speech-Language Pathology

Rule 3.9: Documentation

A. Speech therapy providers must document and maintain records in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3.

B. Required documentation by servicing speech therapy provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment,

4. Original copies of all Outpatient Therapy Evaluation/Re-Evaluations specific to the therapy ordered,

5. The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy ordered,

6. The original copies of all tests performed or a list of all tests performed, test results, and the written evaluation reports,

7. Treatment log if treatment times are not documented in the progress notes including all requirements for timed codes as follows:

a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

c) The Division of Medicaid considers the following activities as not part of the total treatment time:

1) Pre and post-delivery of services,

2) Time the beneficiary spends not being treated, and

3) Time waiting for equipment or for treatment to begin.

d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress notes:

a) Must be documented at least weekly.

b) Must include:

1) Date/time of service,

2) Specific treatment modalities/procedures performed,

3) Beneficiary's response to treatment,

4) Functional progress,

5) Problems interfering with progress,

6) Education/teaching activities and results,

7) Conferences,

8) Progress toward discharge goals/home program activities, and

9) The signature and title of the therapist providing the service(s).

c) If treatment times are documented in the progress notes in lieu of a treatment log, all requirements for timed codes must be met as follows:

1) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

2) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

3) The Division of Medicaid considers the following activities as not part of the total treatment time:

(a) Pre and post-delivery of services,

(b) Time the beneficiary spends not being treated, and

(c) Time waiting for equipment or for treatment to begin.

4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

9. Discharge summary, if applicable, and

10. A copy of the completed prior authorization form, if applicable.

C. Required documentation by prescribing provider must include, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen (face-to-face) and evaluated/re-evaluated every six (6) months at a minimum.

D. The prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

Source: 42 C.F.R. §§ 422.504, 485.715; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/20.

Title 23: Division of Medicaid

Part 213: Therapy Services

Chapter 1: Physical Therapy

Rule 1.11: Documentation

A. Physical therapy ~~P~~provider records must ~~be~~ document~~ed~~ and maintain~~ed~~ records in accordance with requirements set forth in Miss. Admin. Code Part 200, ~~Chapter 1,~~ Rule 1.3. ~~in addition to the provider specific requirements outlined below:~~

~~A~~B. ~~Servicing providers must maintain documentation~~Required documentation by a servicing physical therapy provider ~~including~~includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment~~, if applicable~~,

4. ~~The o~~Original copies of all Outpatient Therapy Evaluation/Re-Evaluation specific to the therapy ~~requested~~ordered,

5. The original copies of all Outpatient Therapy Plan of Care specific to the therapy requested,

6. The original copies of all tests performed or a list of all tests performed, test results, and the written evaluation reports,

7. ~~Specific documentation for timed procedure codes. If a t~~Treatment log ~~is used, it must be retained as part of the beneficiary's medical record,~~ if treatment times are not documented in the progress notes including all requirements for timed codes as follows:

   a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

   b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

   c) The Division of Medicaid considers the following activities as not part of the total treatment time:

      1) Pre and post-delivery of services,

2) Time the beneficiary spends not being treated, and

3) Time waiting for equipment or for treatment to begin.

4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress nNotes:

a) ~~If the beneficiary is receiving therapy one (1) or more times per week, progress notes~~ Mmust be documented at least weekly.~~,~~

b) Must include:~~If treatment intervals exceed weekly, progress notes must be documented following each therapy session,~~

~~c) Progress notes should include:~~

1) Date/time of service,

~~b~~2) Specific treatment modalities/procedures performed,

~~c~~3) Beneficiary's response to treatment,

~~d~~4) Functional progress,

~~e~~5) Problems interfering with progress,

~~f~~ 6) Education/teaching activities and results,

~~g~~7) Conferences,

~~h~~8) Progress toward discharge goals/home program activities, and

~~i~~9) The signature and title of the therapist providing the service(s).

c.~~d~~) If treatment times are documented in the p~~P~~rogress n~~N~~otes in lieu of a t~~T~~reatment l~~L~~og, all requirements for timed codes must be met as follows:

1) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

2) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

3) The Division of Medicaid considers the following activities as not part of the total treatment time:

~~i~~1(a) Pre and post-delivery of services. ~~The beneficiary must be in the treatment area and prepared to start treatment~~,

~~ii~~(b~~2~~) Time the beneficiary spends not being treated, and

~~iii~~3(c) Time waiting for equipment or for treatment to begin.

~~2~~4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

~~e~~5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

~~f~~6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

9~~10~~. Discharge s~~S~~ummary, if applicable, and

10~~1~~. A copy of the completed prior approval authorization form with prior approval ~~authorization~~, if applicable.

~~B~~C. ~~Prescribing providers must maintain~~ Required documentation by prescribing providers must include~~ing~~, but is not limited to, the following:

1. Date(s) of service,
2. Beneficiary demographic information,
3. Signed consent for treatment~~, if applicable,~~
4. Medical history-/chief complaint,
5. Diagnosis,
6. Specific name/type of all diagnostic studies and results/findings of the studies,
7. Treatment rendered and response to treatment,
8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders,

12. Evidence that the beneficiary was seen face-to-face and evaluated/re-evaluated every six (6) months at a minimum.~~, and~~

D.~~13~~. In addition, the prescribing provider must retain c~~C~~opies of the rendering provider's/ therapist's documentation as follows:

~~a~~1.~~)~~ Initial therapy evaluation and all re-evaluations,

~~b~~2.~~)~~ Initial plan of care and all revisions,

~~c~~3.~~)~~ Written evaluation reports for all tests, and

~~d~~4.~~)~~ Discharge summary, if applicable.

Source: 42 C.F.R. §§ 422.504, 485.713; Miss. Code Ann. §§ 43-13-117,43-13-121 ~~43-13-117; 43-13-118; 43-13-129~~.

History: Revised eff. 01/01/20.

Chapter 2: Occupational Therapy

Rule 2.9: Documentation

A. Occupational t~~T~~herapy providers must document and maintain ~~auditable~~ records ~~that meet~~in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3. ~~and those outlined:~~

~~1~~B. ~~The servicing provider must maintain~~ Required documentation by an occupational therapy servicing provider ~~includin~~includes~~g~~, but is not limited to, the following:

1. ~~a)~~ Beneficiary demographic information,

2. ~~b)~~ A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

~~c)~~3. Signed consent for treatment, ~~if applicable,~~

4. ~~d) The o~~Original copies of all Outpatient Therapy Evaluation/Re-Evaluation forms specific to the therapy ~~request~~ordered,

5. ~~e) The o~~Original copies of all Outpatient Therapy Plan of Care forms specific to the therapy ~~requested~~ordered,

~~f)~~6. ~~The o~~Original copies of all tests performed or a list of all tests performed,~~and~~ test results, and the written evaluation reports,

~~g)~~7. ~~Specific documentation for timed procedure codes. If a t~~Treatment log ~~is used, it must be retained as part of the beneficiary's medical record,~~ if treatment times are not documented in the progress notes including all requirement sofr timed codes as follows:

a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

c) The Division of Medicaid considers the following activities as not part of the total treatment time:

1) Pre and post-delivery of services,

2) Time the beneficiary spends not being treated, and

3) Time waiting for equipment or for treatment to begin.

d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

~~h)~~8. ~~Progress n~~Notes:

a) ~~If the beneficiary is receiving therapy one (1) or more times per week, progress notes must be documented at least weekly. If treatment intervals exceed weekly, progress notes must be documented following each therapy session~~Must be documented at least weekly.

b) ~~Progress notes should~~ Must include:

~~i~~1) D~~d~~ate/time of service,

~~ii~~2) S~~s~~pecific treatment modalities/procedures performed,

~~iii~~3) ~~b~~Beneficiary's response to treatment, functional progress,

~~iv~~4) ~~p~~Problems interfering with progress,

~~v~~5) ~~e~~Education/teaching activities and results,

~~vi~~6) ~~c~~Conferences,

~~vii~~7) ~~p~~Progress toward discharge goals/home program activities, and

~~viii~~8) ~~t~~The signature and title of the therapist providing the service(s).

~~i~~c.) If treatment times are documented in the p~~P~~rogress n~~N~~otes in lieu of a t~~T~~reatment l~~L~~og, all requirements for timed codes must be met as follows:~~.~~

1) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

2) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

3) The Division of Medicaid considers the following activities as not part of the total treatment time:

(a) Pre and post-delivery of services. ,

(b) Time the beneficiary spends not being treated, and

(c) Time waiting for equipment or for treatment to begin.

4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

~~jj~~9.~~)~~ ~~———~~Discharge Summary, if applicable, and

~~kj)~~10. ~~———~~A copy of the completed prior approval form with prior approval authorization, if applicable.

~~B~~C. ~~The prescribing provider must maintain~~Required documentation by a prescribing occupational therapy provider includ~~in~~es~~g~~, but is not limited to, the following:

1. Date(s) of service,
2. Beneficiary demographic information,
3. Signed consent for treatment~~, if applicable~~,
4. Medical history/chief complaint,
5. Diagnosis,
6. Specific name/type of all diagnostic studies and results/findings of the studies,
7. Treatment rendered and response to treatment,
8. Medications prescribed including name, strength, dosage, and route,
9. Orders that are signed and dated for all medications, treatments, and procedures rendered,
10. Discharge planning and beneficiary instructions,
11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and
12. Evidence that the beneficiary was seen, face-to-face, and evaluated/re-evaluated every six (6) months, at a minimum.

~~C~~D. ~~In addition, t~~The prescribing occupational therapy provider must retain copies of the rendering provider's/ therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,
2. Initial plan of care and all revisions,
3. Written evaluation reports for all tests, and
4. Discharge summary, if applicable.

~~D. The servicing provider or licensed therapist is responsible for providing a copy of all required therapy documentation as noted above to the prescribing provider~~.

~~E. Timed c~~Codes~~:~~

~~1. Medicaid defines procedure codes that reference a time per unit as 'timed codes.' Providers must bill units of timed codes based upon the total time actually spent in the delivery of the service. The total treatment time, including the actual beginning and ending time of treatment, must be recorded for services described by time codes. All of the times, as well as the description of the treatment modalities/procedures that were provided, must be recorded for each visit. The therapist rendering treatment must sign, with signature and title, and date each entry. Documentation may be recorded in the Progress Notes or on a treatment log. If a treatment log is used, it must be retained as part of the beneficiary's medical record. part of the beneficiary's medical record.~~

~~2. Activities that are not considered part of the total treatment time include, but are not limited to, the following:~~

~~a) Pre and post-delivery services - The beneficiary should be in the treatment area and prepared to start treatment,~~

~~b) Time the beneficiary spends not being treated, and~~

~~c) Time waiting for equipment or for treatment to begin.~~

~~3. Medicaid defines 'Untimed' procedure codes as no specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Whether the service took ten (10) minutes or two (2) hours to complete, only one (1) unit can be billed because only one (1) service was provided. The name and title of the person supervising the treatment/modality must be recorded for all procedure codes requiring direct supervision.~~

Source: 42 C.F.R. §§ 422.504, 485.715; Miss. Code Ann. §§ 43-13-117, ~~43-13-118,~~ 43-13-121, ~~43-13-117; 43-13-118, 43-13-129~~.

History: Revised eff. 01/01/20.

Chapter 3: Outpatient Speech-Language Pathology

Rule 3.9: Documentation

A. Speech therapy providers must document and maintain records in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3.

B. Required documentation by servicing speech therapy provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment~~, if applicable~~,

4. ~~The o~~Original copies of all Outpatient Therapy Evaluation/Re-Evaluations specific to the therapy ~~requested~~ordered,

5. The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy ~~requested~~ordered,

6. The original copies of all tests performed or a list of all tests performed,~~and~~ test results, and the written evaluation reports,

7. ~~Specific documentation for timed procedure codes. If a treatment~~ Treatment log ~~is used, it must be retained as part of the beneficiary's medical record,~~ if treatment times are not documented in the progress notes including all requirements for timed codes as follows:

   a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

   b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

   c) The Division of Medicaid considers the following activities as not part of the total treatment time:

      1) Pre and post-delivery of services,

      2) Time the beneficiary spends not being treated, and

      3) Time waiting for equipment or for treatment to begin.

   d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

   e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

   f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress n~~N~~otes:

   a) ~~If the beneficiary is receiving therapy one or more times per week, progress notes must be documented at least weekly. If treatment intervals exceed weekly, progress notes must be documented following each therapy session~~Must be documented at least weekly.

b) ~~Progress notes should~~ Must include:

1) ~~d~~Date/time of service,

2) ~~s~~Specific treatment modalities/procedures performed,

3) ~~b~~Beneficiary's response to treatment,

4) ~~f~~Functional progress,

5) ~~p~~Problems interfering with progress,

6) ~~e~~Education/teaching activities and results,

7) ~~c~~Conferences,

8) ~~p~~Progress toward discharge goals/home program activities, and

9) ~~t~~The signature and title of the therapist providing the service(s).

c) If treatment times are documented in the p~~P~~rogress n~~N~~otes in lieu of a t~~T~~reatment l~~L~~og, all requirements for timed codes must be met~~. Refer to timed and untimed codes in this Part~~ . as follows:

1) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

2) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

3) The Division of Medicaid considers the following activities as not part of the total treatment time:

(a) Pre and post-delivery of services,

(b) Time the beneficiary spends not being treated, and

(c) Time waiting for equipment or for treatment to begin.

4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

9. Discharge s~~S~~ummary, if applicable, and

10. A copy of the completed prior ~~approval~~ authorization form ~~with prior approval authorization~~, if applicable.

C. Required documentation by prescribing provider must include~~s~~, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment, ~~if applicable,~~

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen (face-to-face) and evaluated/re-evaluated every six (6) months at a minimum.

D. ~~In addition, t~~The prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

~~E. Timed c~~Codes~~:~~

~~1. Procedure codes that reference a time per unit are 'timed codes.' Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.~~

~~2. Medicaid considers the following activities as not part of the total treatment time:~~

~~a) Pre and post delivery services. The beneficiary should be in the treatment area and prepared to start treatment,~~

~~b) Time the beneficiary spends not being treated, or~~

~~c) Time waiting for equipment or for treatment to begin.~~

~~F. Untimed procedure codes are not defined by a specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.~~

Source: 42 C.F.R. §§ 422.504, 485.715; Miss. Code Ann. §§ ~~43-13-121;~~ 43-13-117~~;~~ ~~,~~ ~~43-13-118;~~ 43-13-121~~;~~ ~~43-13-129~~.

History: Revised eff. 01/01/20.